AG-099 (10-98)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Aging & Adult Administration
FACILITY/OMBUDSMAN REPORT

Purpose. This form is to be completed when a complaint is received by the Certified Ombudsman Program. Send a copy to State Ombudsman Office.

Ombudsman's Name	Date Complaint Received	Date Closed

Name of Facility Where Reported Complaint Occurred	Client on ALTCS
	☐ YES ☐ NO

1. Complaint was primarily against or pertaining to (check [✓] only one)

☐ Skilled Nursing Facility ☐ Unlicensed Home ☐ Physician
☐ Assisted Living Center ☐ ALTCS/AHCCCS ☐ Legal Representative
☐ Assisted Living Home ☐ Resident ☐ Medicare
☐ Adult Foster Care ☐ Family Member ☐ Other *(Specify)* _____

2. Ethnic Category (check [✓] applicable one)

☐ Native American Indian ☐ Asian ☐ Black/African-American
☐ Caucasian ☐ Hispanic ☐ Unknown/multi ☐ Other *(Specify)* _____

3. Reporting Source (check [✓] applicable one)

☐ Resident ☐ Facility Staff
☐ Relative/friend ☐ Social service program
☐ Non-relative/guardian/legal representative ☐ Other medical person/physician/staff
☐ Ombudsman ☐ Unknown/anonymous ☐ Other *(Specify)* _____

Nature of Complaint

Complaint Code Table

Record the complaint categories as applicable. There should be one category listed per complaint. Use Reference Code Table.

Complaint Code (use reference table)	**Finding Code**		**Disposition Code**	Disposition Code (see below)
	Verified or Partially Verified	Not Verified		
				1. Partially resolved but some problem remained. 2. Complaint was not resolved to satisfaction of resident or complainant. 3. Resolved to the satisfaction or resident or complainant. 4. No action needed/appropriate. 5. Resident or complainant request withdrawn. 6. Policy, regulatory or legislative action required to resolve. 7. Referred to another agency – no action. 8. Referral/no final report.

Facility/Ombudsman Report (AG-099)
Completion Instructions

Purpose
The purpose of the facility ombudsman report is to capture relevant information on complaints received from representatives of the Office of the State Long-Term Care Ombudsman.

First line of boxes

Ombudsman's Name - enter the name of the representative filling out the form.
Date Complaint Received - enter the date the complaint was received.
Date Closed - enter the date when all of the complaints listed on the form were addressed.

Second line of boxes

Name of Facility Where Reported Complaint Occurred – enter the name of the facility where the complaint occurred.
Client on ALTCS – check the appropriate box to identify whether or not the client is on the Arizona Long-Term Care Ombudsman System.

Items 1-3

1. Complaint Was Primarily Against or Pertaining To – check the box that best identifies whom the complaint is against or pertaining to. Only one box may be checked.
2. Ethnic Category - if the complaint involves a specific person, check the box that best identifies the person's ethnicity. Only one box may be checked.
3. Reporting Source - check the box that best identifies the person who is making the complaint. Only one box may be checked.

Nature of Complaint Section

As needed, use the space provided to further explain the nature of the complaint or to indicate future follow-up.

Complaint Code Table Section

Complaint Code Column– enter the complaint code that most appropriately identifies the complaint for each complaint made. Up to four complaint codes may be entered per report form. Please refer to the document titled "Long-Term Care Ombudsman Program Complaint Codes" that was distributed during the Ombudsman CORE training for a listing of the complaint codes. The table may also be accessed on the Administration on Aging website (www.aoa.gov).

Findings Code Columns – for each complaint, check whether the complaint was "verified or partially verified" or "not verified".

Disposition Code Column– for each complaint, enter one of the eight options from the Disposition Code column that best identifies the outcome of the complaint.